FBMC
Premier Benefits Solutions
P.O. Box 1878 Tallahassee, FL 32302-1878

Plan Year 2010
SOUTH CAROLINA BUDGET & CONTROL BOARD
EMPLOYEE INSURANCE PROGRAM MONEYPLU$ ENROLLMENT FORM

Please be sure to read the* IMPORTANT *information on the back of this form.
Submit your completed form to your Benefits Administrator.
Please press hard with a black ballpoint pen.

You must complete this form if you wish to start a tax-free Medical Spending and/or Dependent Care Spending Account or to enroll in or change a Health Savings Account.

Name (Please Print) Last	First	MI	Social Security #

Mailing Address Street (HSA participants cannot list a P.O. Box.)	City	State	ZIP Code	Date of Birth
				/ /

Physical Address Street	City	State	ZIP Code	Annual Salary
				$

Daytime Phone	Home Phone	Date of Hire	E-mail Address
( )	( )	/ /	

Complete **Section A** to enroll in or to change a **Health Savings Account**. (Additional forms will be required to establish your HSA. Refer to your ***Tax-Favored Accounts Guide*** for more information.) If you would also like to enroll in a **limited-use Medical Spending Account** for eligible dental and vision expenses, complete **Section B**. To enroll in a **Medical Spending Account**, complete **Section C**. To enroll in a **Dependent Care Spending Account**, complete **Section D**. In **Box #1**, indicate the dollar amount you elect to contribute for the upcoming plan year. In **Box #2**, indicate the number of regular payroll checks you will receive during the upcoming plan year. In **Box #3**, indicate the reduction amount per paycheck. (Note: If Box #2 times Box #3 does not equal Box #1 exactly, the amount in Box #3 may be changed slightly by FBMC due to rounding.)

A Health Savings Account (Additional forms are required.)

☐ NEW ACCOUNT ☐ CONTRIBUTION AMOUNT CHANGE

Select which type of SHP Savings Plan coverage you have:
☐ Individual ($3,050 maximum in 2010) ☐ Family ($6,150 maximum in 2010)
☐ Over 55 Catch-up (additional maximum $1,000)

	EMPLOYEE	FOR BA USE ONLY: EMPLOYER
Box #1 2010 Plan Year Total Dollar Amount (January 1, 2010 – December 31, 2010)		
Box #2 Pay Period Election ÷		
Box #3 Reduction Per Regular Paycheck =		

NBSC will deduct a $1 monthly administrative fee from your HSA.
FBMC will deduct a $1 monthly administrative fee from your paycheck.

B Limited-use Medical Spending Account

☐ NEW ENROLLMENT ☐ RE-ENROLLMENT (Available to HSA Participants only)

Receive reimbursement for eligible dental and vision expenses incurred by you, your family members or both. [Maximum allowable contribution is $5,000 annually.]

Box #1 2010 Plan Year Total Dollar Amount (January 1, 2010 – December 31, 2010) _____

Box #2 Number of Regular Paychecks ÷ _____

Box #3 Reduction Per Regular Paycheck = _____

Your payroll center will automatically deduct the monthly fee of $3.50 in addition to the above amounts.

IF YOU ENROLL IN A HEALTH SAVINGS ACCOUNT (SECTION A), YOU CANNOT ENROLL IN A MEDICAL SPENDING ACCOUNT (SECTION C), BUT MAY ENROLL IN A LIMITED-USE MEDICAL SPENDING ACCOUNT (SECTION B).

C Medical Spending Account

☐ NEW ENROLLMENT ☐ RE-ENROLLMENT

Receive reimbursement for eligible medical expenses incurred by you, your family members or both. [Maximum allowable contribution is $5,000 annually.]

Box #1 2010 Plan Year Total Dollar Amount (January 1, 2010 – December 31, 2010) _____

Box #2 Number of Regular Paychecks ÷ _____

Box #3 Reduction Per Regular Paycheck = _____

Your payroll center will automatically deduct the monthly fee ($3.50) in addition to the above amounts.

DO YOU WISH TO PARTICIPATE IN THE myFBMC Card℠ PROGRAM? ☐ **YES** ☐ **NO**
If you select the card, your Medical Spending Account will be assessed a $10 per-plan-year fee.
Note: You must select "**YES**" above if you wish to continue using your myFBMC Card℠.

D Dependent Care Account

☐ NEW ENROLLMENT ☐ RE-ENROLLMENT

Tax filing status, please check one:
☐ Married, filing separately (Maximum - $2,500) ☐ Single, head of household (Maximum - $5,000) ☐ Married, filing jointly (Maximum - $5,000)

Box #1 2010 Plan Year Total Dollar Amount (January 1, 2010 – December 31, 2010) _____

Box #2 Number of Regular Paychecks ÷ _____

Box #3 Reduction Per Regular Paycheck = _____

Your payroll center will automatically deduct the monthly fee ($3.50) in addition to the above amounts.

☐ I plan to retire or terminate my employment prior to December 31, 2010. I wish to have my full amount (in Box #1 of any and all accounts) withheld from my first _____ paychecks (this number should be less than Box #2 of any and all accounts).

Please read reverse side before signing this form below.

EMPLOYEE SIGNATURE:	**DATE:**

FOR BA USE ONLY:

For MONEYPLU$ eligibility purposes, I certify that this employee is eligible for the Account(s) in which the employee is enrolling. If the employee has enrolled in an HSA, I certify that the employee is also enrolled in the State Health Plan Savings Plan, and, if applicable, has correctly accounted for the Employer Contribution.

EMPLOYER/BENEFITS ADMINISTRATOR SIGNATURE: _____ **DATE:** _____

Effective Date _____ Payroll Date _____ Payroll Center _____ Payroll Frequency _____ Group Number _____

FBMC USE ONLY

DATA ENTRY	VERIFICATION	SCANNED	INDEXED

BENEFITS ADMINISTRATORS: Send signed form to: Enrollment Processing, P.O. Box 1878 Tallahassee, FL 32302-1878

IMPORTANT

General (Applies to all Sections)

- I hereby authorize my employer to reduce my gross salary, before taxes are calculated, by the total amount of annual salary deduction indicated on reverse.
- I understand that the funds in one Account cannot be used to reimburse expenses covered by another Account.
- I understand that expenses for which I am reimbursed cannot be deducted on my income tax return.
- I certify that I expect to receive the number of paychecks listed in Box #2 of any and all Sections, unless the early retirement/termination box is also selected.

Health Savings Accounts (Section A)

- I understand when starting an HSA and electing my initial HSA contribution amount, **I am required to complete additional forms available through the custodial bank link (*Open HSA Bank Account*) on EIP's Web site**. (Refer to your ***MONEYPLU$ Tax-Favored Accounts Guide*** for more information.) I also understand my HSA will not be created until this documentation is properly completed and received by the HSA Custodian.
- If I have enrolled in an HSA, I certify that I am covered by the State Health Plan Savings Plan (High-Deductible Health Plan), and I am not covered by a health plan other than an HDHP that provides any of the same benefits as an HDHP. I have reviewed and agree to the terms and conditions found in the Health Savings Custodial Account, Disclosure Statement and Funds Availability Disclosure Statement amendments thereto. *(Contact your benefits administrator for a copy of this statement.)* I assume sole responsibility for all consequences relating to my actions concerning this HSA. I understand that I may revoke this HSA on or before seven (7) days after the date of establishment as outlined in the Funds Availability Disclosure Statement. *(Contact FBMC Customer Care at 1-800-342-8017.)* I have not received any tax or legal advice from the custodian, and I will seek the advice of my own tax or legal professional to ensure my compliance with related laws. I release and agree to hold the HSA custodian harmless against any and all claims or losses arising from my actions. I also understand: 1) the HSA maximum contributions, established by the federal government and subject to change, are tied to the rate of inflation; 2) the maximum monthly contribution is calculated based on the annual allowable amount and number of months remaining in the contribution year; and 3) a subscriber age 55 and older may make "catch-up" contributions to an HSA (in 2010, that subscriber can contribute up to $1,000 above the limit).
- **I understand I can change my HSA contribution once a month.** The change is effective at the beginning of the first month after the change is requested. Re-enrollment is not required each plan year.

Spending Accounts (Sections B, C & D)

- I understand that the funds in any Spending Account can only be paid to reimburse payment of eligible expenses actually incurred during my period of coverage and any applicable grace period. (There is no grace period for Dependent Care Spending Accounts.)
- I understand that any amount remaining in any Spending Account not used during this plan year, and following any applicable grace period (**ending March 15**) will be forfeited since it cannot be carried forward to the next plan year. *You have a 90-day run-out period (**until March 31**) at the end of the plan year for reimbursement of eligible Spending Account expenses incurred during your period of coverage within the plan year and any applicable grace period.*
- I understand that the amount of salary deduction will include the items specified on the reverse side of this form and will continue in effect unless I terminate employment or file an approved Change in Status form with the contract administrator within 31 days of the event.
- I understand and agree that my employer and Fringe Benefits Management Company, the contract administrator, will not incur any liability resulting from either my participation in any Account or my failure to sign or accurately complete this Enrollment Form. I further understand that if I elect not to participate in salary deduction with respect to the benefits listed on the reverse side, I hereby forego my right to participate during the upcoming plan year.
- I certify that: 1) I will only use my Spending Account to pay for IRS-qualified expenses eligible under my employer's plan, and only for me and my IRS-eligible dependents; 2) I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my Spending Account; 3) I will not seek reimbursement through any additional source; and 4) I will collect and maintain sufficient documentation to validate the foregoing.

Direct Deposit Authorization

- I hereby authorize Fringe Benefits Management Company (FBMC) to initiate credit entries to the custodian bank for deposit into my HSA in accordance with my HSA election. I also authorize FBMC to initiate, if necessary, debit entries and adjustments for any credit entries made in error. This authorization is to remain in full force and effect until FBMC has received written notice from me of its termination in such time and manner as to afford FBMC and the custodian bank a reasonable opportunity to act on it.